

MDR Tracking Number: M5-04-2210-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 3-19-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The therapeutic procedures, chiropractic manipulation, massage therapy, electrical stimulation, and ultrasound therapies from 12/30/03 through 12/31/03 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed service.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 12/30/03 through 12/31/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 7<sup>th</sup> day of June 2004.

Regina L. Cleave  
Medical Dispute Resolution Officer  
Medical Review Division

RLC/rlc

May 20, 2004

MDR #: M5-04-2210-01  
IRO Certificate No.: 5055

\_\_\_ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, \_\_\_ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of \_\_\_ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

## **REVIEWER'S REPORT**

### **Information Provided for Review:**

TWCC-60, Table of Disputed Services, EOB's  
Correspondence from Requestor: 09/26, 10/29, 11/07, 11/21, 11/24, 12/10, 12/22/2003, 01/12, 02/02, 02/09, 02/19, 03/08, 03/12, 03/19, 03/23, & 04/02/2004.  
Clinical information – pain management 11/11, 12/18/2003, 02/17 & 04/01/2004  
Modality reviews 01/22 & 03/09/2004; MRI lumbar spine 11/04/2003.  
Operative notes 12/04/2003, 01/15 & 03/04/2004.  
Daily records 09/26/03 through 01/30/04.

### **Clinical History:**

The records indicate the patient was originally injured on \_\_\_. He underwent extensive conservative chiropractic care and physical therapy. Based upon his lack of response to treatment, a lumbar MRI was performed on November 4, 2003, that was positive for disc involvement. At that time, he was referred to a specialist who recommended lumbar ESIs. On December 4, 2003, he received his first lumbar ESI. After which the specialist recommended post-injection therapy.

### **Disputed Services:**

Therapeutic procedures, chiropractic manipulation, phys treatment 1 area, massage therapy, electrical stimulation 1/more areas and ultrasound therapy during the period of 12/30/03 and 12/31/03.

**Decision:**

The reviewer disagrees with the determination of the insurance carrier and is of the opinion that the treatment and therapy in dispute as stated above was medically necessary in this case.

**Rationale:**

National treatment guidelines allow for this type of treatment for this type of injury. There is sufficient documentation provided to clinically justify and warrant each denied service. In conclusion, it was in fact reasonable, usual, customary, and medically necessary for this patient to receive therapeutic procedure, chiropractic manipulation, physical treatment 1 area, massage, electric stimulation x1 or more area, and ultrasound therapy on 12/30/03 and 12/31/03.

Sincerely,